Appendix 10
Prior Authorization Request Form
Spell of Illness Sample (Occupational Therapy)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 115

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567892
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, ImA.
4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow St. Anytown, WI 55555
5 DATE OF BIRTH: MM/DD/YY
6 SEX: M ☐ F ☒
8 BILLING PROVIDER TELEPHONE NUMBER: (XXX)XXX-XXXX
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I. M. Provider, 1 W. Williams, Anytown, WI 55555
9 BILLING PROVIDER NO.: 10000000
10 DX: PRIMARY: 854T.B.I.
11 DX: SECONDARY: 814.0 (R) Wrist fx.
12 START DATE OF SOI: MM/DD/YY
13 FIRST DATE RX: MM/DD/YY

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
Q0109	0T	8	9	Evaluation	01	
97535	0T	8	9	Act of daily living (each 15 min.)	34	
97770	0T	8	9	Cognitive - memory (each 15 min.)	34	
97110	0T	8	9	Range of motion (each 15 minutes)	34	
97265	0T	8	9	Joint mob. periph. (initial 15 min.)	12	
97250	0T	8	9	Myofas. Rel/Soft tissue (each 15 min.)	34	
*Each session will include 30 min. ADL and combination of other procedures to *equal* one hour of treatment					TOTAL CHARGE	21

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)
24 *I.M. Provider* Begin SOI MM/DD/YY (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:
☐ APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED
☐ MODIFIED — REASON:
☐ DENIED — REASON:
☐ RETURN — REASON:

DO NOT write in this space.
Reserved for Medicaid use.

DATE — CONSULTANT/ANALYST SIGNATURE

482-120

Appendix 10a
Prior Authorization Request Form for Spell of Illness
Completion Instructions (Occupational Therapy)

Element 1 - Processing Type
Enter processing type 115, occupational therapy (spell of illness only).

Element 2 - Recipient's Wisconsin Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 3 - Recipient's Name
Enter the recipient's last name, followed by first name and middle initial, from the recipient's current identification card.

Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41) from the recipient's current identification card.

Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

Element 7 - Billing Provider's Name, Address, and Zip Code
Enter the billing provider's name and complete address (street, city, state, and zip code). *No other information should be entered in this element since it also serves as a return mailing label.*

Element 8 - Billing Provider's Telephone Number
Enter the *billing provider's* telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 - Billing Provider's Wisconsin Medicaid Provider Number
Enter the billing provider's eight-digit provider number.

Element 10 - Recipient's Primary Diagnosis
Enter the appropriate International Classification of Diseases, 9th Revision, Clinical Modification diagnosis *code and description most* relevant to the service/procedure requested.

Element 11 - Recipient's Secondary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description* additionally descriptive of the recipient's clinical condition.

Element 12 - Start Date of Spell of Illness
Enter the date of onset for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 13 - First Date of Treatment
Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 14 - Procedure Code(s)
Enter the procedure code as described in the plan of care.

Element 15 - Modifier
Enter the "OT" modifier appropriate for each procedure code.

Element 16 - Place of Service
Enter the appropriate place of service code.

Numeric	Description
0	Other
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

Element 17 - Type of Service
Enter the appropriate type of service code for each service/procedure/item requested. This includes therapy services and therapy spells of illness (occupational therapy).

Numeric	Description
1	Medical
9	Rehabilitation Agency

Element 18 - Description of Service
Enter the appropriate procedure code description.

Element 19 - Quantity of Service Requested
Enter the number of treatment days requested, per procedure code.

Element 20 - Charges (leave this element blank)

Element 21 - Total Charge (leave this element blank)

Element 22 - Billing Claim Payment Clarification Statement
Please read the "Billing Claim Payment Clarification Statement" printed on the request before dating and signing the prior authorization request form.

> "An approved authorization does not guarantee payment. Payment is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Payment is in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid-contracted managed care program at the time a prior authorized service is provided, Medicaid payment is allowed only if the service is not covered by the managed care program."

Element 23 - Date
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

Element 24 - Requesting Provider's Signature
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

**Do not enter any information below the signature of the requesting provider -
This space is reserved for Medicaid consultant(s) and analyst(s).**

Appendix 11
Sample Prior Authorization Spell of Illness Attachment

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT
(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Im	A	1234567890	55

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
I.M. Performing, OTR	87654321	(XXX) XXX -XXXX

(9) I. M. Referring
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. ☐ Physical Therapy SOI ☒ Occupational Therapy SOI ☐ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems.
Indicate the functional regression which has occurred and the potential to reachieve the previous skill level.
Recipient was involved in M.V.A. MM/DD/YY with resultant T.B.I with coma and other multiple internal injuries and orthopedic complications. Acute hospitalization and follow-up rehabilitation on MM/DD/YY. Recipient was discharged home on MM/DD/YY. Upon discharge to home, recipient was able to ambulate without assistance, perform all ADLs with minimal cueing from memory book and relied on memory book to perform cognitive tasks. Family completed housekeeping tasks. Nine months later, regression in the ability to perform self care was noted, and was admitted to a nursing home for the purpose of regaining functional abilities.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.
SeeAttached

D. What is the anticipated end date of the spell of illness?
MM/DD/YY

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. *I. M. Prescribing* — Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) — MM/DD/YY — Date

G. *I M Performing* — Signature of Therapist Providing Evaluation/Treatment — MM/DD/YY — Date

Appendix 11a
Prior Authorization Spell of Illness Attachment
Completion Instructions

Do not use this attachment to request prior authorization (PA) to extend treatment beyond 35 treatment days for the same spell of illness; use the Prior Authorization Therapy Attachment (PA/TA).

Timely determination of PA is significantly increased by submitting thorough documentation when requesting PA for a spell of illness. Carefully complete the Prior Authorization Spell of Illness Attachment (PA/SOIA) form, attach it to the Prior Authorization Request Form (PA/RF), and submit to:

Prior Authorization, Suite 88
EDS
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding the completion of the PA/RF and/or PA/SOIA may be directed to the fiscal agent's Policy/Billing Correspondence Unit. Telephone numbers are in Appendix 2 of Part A, the all-provider handbook.

Recipient Information:

Element 1 - Recipient's Last Name
Enter the recipient's last name from the recipient's current identification card.

Element 2 - Recipient's First Name
Enter the recipient's first name from the recipient's current identification card.

Element 3 - Recipient's Middle Initial
Enter the recipient's middle initial from the recipient's current identification card.

Element 4 - Recipient's Wisconsin Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 5 - Recipient's Age
Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

Provider Information:

Element 6 - Therapist's Name and Credentials
Enter the name and credentials of the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter his/her name and credentials, also enter the name of the supervising therapist.

Element 7 - Therapist's Wisconsin Medicaid Provider Number
Enter the eight-digit provider number of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter his/her provider number, also enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 8 - Therapist's Telephone Number
Enter the telephone number, including area code, of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter his/her telephone number and the telephone number of the supervising therapist.

Element 9 - Referring/Prescribing Physician's Name

Enter the name of the physician referring/prescribing evaluation/treatment.

Part A

Enter an "X" in the appropriate box to indicate a physical, occupational, or speech therapy spell of illness request.

Part B

Enter a description of the recipient's diagnosis and problems. Indicate what functional regression has occurred and what the potential is to reachieve the previous skill.

Part C

Attach a copy of the recipient's Therapy Plan of Care, including a current dated evaluation, to the Spell of Illness attachment before submitting the spell of illness request.

Part D

Enter the anticipated end date of the spell of illness in the space provided.

Part E

Attach the physician's dated signature on either the Therapy Plan of Care or the copy of the physician's order sheet. Read the 'Prior Authorization Statement' before signing and dating the attachment.

Part F

The signature of the prescribing physician and the date must appear in the space provided. (A signed copy of the physician's order sheet is acceptable.)

Part G

The dated signature of the therapist providing evaluation/treatment must appear in the space provided.

Appendix 12
Spell of Illness Guide

The following table includes some examples to help providers determine when to submit a spell of illness form versus a prior authorization (PA) form.

Injury/Illness	Submit PA/Spell of Illness Forms?	Treatment Days	Submit PA/TA Form?
First time in treatment (femoral fracture)	no	30 days	n/a
Second time in treatment (mild CVA-ability to reachieve ADLS is possible)	yes	65 days	Submit the PA/RF and PA/TA forms to the fiscal agent within two weeks before spell of illness ends for additional 30 days
Third time in treatment (decubitus ulcer)	The diagnosis never qualifies for a spell of illness.	100 days	Submit PA/RF and PA/TA forms to the fiscal agent within two weeks of evaluation.
Fourth time in treatment (humeral fracture)	yes	26 days	n/a
Fifth time in treatment (severe CVA-ability to reachieve ADLS is questionable)	Does not qualify as spell of illness	14 days	Submit PA/RF and PA/TA forms to the fiscal agent within two weeks of evaluation.

Appendix 13
Helpful Hints for Working With Wisconsin Medicaid

The following tips are a compilation of information collected from providers participating in the Wisconsin Occupational Therapy Association (WOTA) Medicaid Committee and information presented at symposiums sponsored by the committee. The information has been edited and updated by the Bureau of Health Care Financing therapy consultants. These tips are meant as guidelines to improve your documentation and to assist you in completing Medicaid forms accurately and completely.

Prior Authorizations (PAs)

- If information regarding the recipient's previous therapy history is unavailable, submit a PA request.
- Fill out all forms completely and accurately. Each time a PA request is sent back to the provider for more information, there is a delay in services.
- A PA request should be sent to the fiscal agent at least two weeks, but no more than three weeks, before the expiration date of the existing prior authorization.
- Check the recipient's 10-digit identification number before mailing the request to the fiscal agent.
- Please list onset dates for all diagnoses. If specific dates are not available, enter an approximate date based on the best information available and explain the circumstances.
- Count weeks and sessions accurately to ensure authorizations for sufficient sessions. Count from the requested start date. Remember, the consultant cannot grant more than you request. Please indicate if the recipient has been put "on hold" until the PA is finalized.
- The initial request for PA can be backdated two weeks to the date the request is initially received by the fiscal agent. Continuous therapy may not be backdated. To request backdating, write "Please backdate to (*date)* because (*reason*)" on the prior authorization request form (PA/RF).
- In the event that your initial PA request is returned for clarification, provide written clarification and attach your response to the original PA/RF and return this PA/RF with all attachments to the fiscal agent. The original PA/RF was stamped with the internal control number (ICN) date when it was first received by the fiscal agent. The PA may be backdated to the ICN date only if you specifically request this.
- In cases when you have difficulty getting a doctor's signature on the initial plan of care which has caused your PA to be late, attach a memo of explanation which the fiscal agent may consider in dating your authorization.
- The codes at the bottom of the PA/RF near the consultant's signature are common messages regarding action or recommendations by the consultant which have been assigned a computer code.
- Remember to use black ink. This makes the photocopies easier to read.
- A plan of care must be formulated from a valid data base (evaluation). PAs are not approved if the evaluation results are not included.
- If there is an interruption in services and you have excess sessions to use, you may change frequency if appropriate for the recipient, as long as you don't exceed the number of sessions granted or the end date. Include an explanation of the circumstances on your next PA. An amendment cannot be granted in this case.

Hints (continued)

- You may change your treatment plan during a PA; however, be sure to include the dates and rationale on your next PA request.
- Please write legibly and ensure legibility of copies. If the consultant cannot read your documents, they may get sent back.
- Only use basic or common abbreviations.
- If your PA is returned "denied," you have the right to call the consultant to discuss the decision. If the consultant agrees to change the decision, submit a new PA request with the additional documentation required by consultant. Attach a copy of the denied PA.
- If the consultant stands by the denial, the recipient has the right to appeal through the fair hearing process.
- PAs returned to the provider for more information must be returned to the fiscal agent within a two-week period.
- If the reviewing consultant writes "D/C at end of PA" on the returned PA/RF, and you feel the recipient would benefit from further treatment, write another prior authorization clarifying medical reason for additional treatment.
- Make sure your goals are objective, measurable, and functional.
- Record all progress, no matter how small.
- Include function and safety issues when appropriate.
- Use standardized evaluations whenever possible. Attach the complete evaluation to the PA request. Summarized evaluations usually do not include the full information required by the reviewing consultant to determine medical necessity.
- Include norms with test scores.
- Include specific carryover recommendations for patient, facility, staff, and/or family. After six months, carryover must be demonstrated to grant continued treatment.
- Highlight pertinent data.
- Suggested formats:
  - List your data in columns - past and present.
  - Use areas, problems resolved, problems improved, problems unresolved, carryover.
- Maintenance is a covered treatment, as long as *skilled* therapy services are required.
- "Medical Necessity" is defined in HFS 101.03 (96m), Wis. Admin. Code.

Hints (continued)

Spells of Illness (SOIs)

- New diagnoses or exacerbations that result in a functional regression generally qualify as a spell of illness.
- Be sure to include a copy of the current evaluation, a comparison to prior abilities, and an estimate of the patient's ability to return to prior level of function.
- Remember, any health insurance, including Medicare-paid sessions (excluding inpatient hospital days) *count* toward the original 35 days of treatment for a spell of illness.
- You may submit a copy of the monthly signed doctor's orders in lieu of a signature on the Prior Authorization Therapy Attachment (PA/TA), as long as the order indicates what treatment the doctor is prescribing.

General Information

- BID treatment counts as one session, so long as it does not exceed 90 minutes per day.
- Daily treatment time should not exceed the limitation of 90 minutes, per treatment day. However, under extraordinary circumstances you may request more time. After you receive payment for the 90 minutes, submit an adjustment form with the specific reason for exceeding the 90 minute limitation documented on the adjustment form.
- Make sure treatment and documentation are in accordance with the Wisconsin Administrative Code laws and practice standards.
- Splinting treatment, including evaluation and associated expenses, is billed separately from other treatment sessions as durable medical equipment. Refer to the Durable Medical Equipment (DME) Index for correct procedure codes.

Appendix 14
Wisconsin Medicaid Declaration of Supervision and Authorization to Pay Agreement for Non-Billing Providers

The following providers are issued non-billing provider numbers (*cannot be used independently* to bill Wisconsin Medicaid), must be under professional supervision to be Medicaid-certified providers and *must* complete this form:

Alcohol and Other Drug Abuse Counselor (31/048)
Psychiatric Nurse (31/049)
Master's Level Psychotherapist (31/078)
Physical Therapy Assistant (34/077)
Occupational Therapy Assistant (35/114)
Speech Pathologist, BA Level (78/091)
Physician Assistant (88/079)

Return to: EDS, Attn: Provider Maintenance, 6406 Bridge Road, Madison, WI 53784-0006

To be completed by the applicant who is a Non-Billing Provider or Current Non-Billing Provider who has a Change in Work Address or Supervisor (always required):

Name and Credentials:_____ Phone:(_____)_____

WorkMailingAddress:_____

Since Wisconsin Medicaid payments cannot be made payable to me, I, _____, hereby direct the fiscal agent for Wisconsin Medicaid, EDS, to make checks payable to (clinic or supervisor's name for providers other than mental health) _____ for all claims payments for services performed by me under Wisconsin Medicaid. I understand that this payment arrangement shall continue in effect until the fiscal agent receives a new Declaration of Supervision form from me. When my supervisor, employer or work address changes, I will immediately send this form completed again to the fiscal agent.

_____ _____ _____
Date Signature of Non-Billing Provider Wisconsin Medicaid Provider Number

To be completed by the Supervisor (always required):

Name:_____ Employer IRS #_____ Phone:(_____)_____

Address:_____

I, _____, am supervising the work of _____.
The effective starting date of my supervision was _____. I hereby acknowledge and agree to the above payment arrangement. I understand that if my name is indicated in the above section, Wisconsin Medicaid checks for services provided by the above provider will be payable to me directly and will be reported under the IRS# written here. If I discontinue supervision of the above, I understand that I must send notice to the fiscal agent at the above address.

_____ _____ _____
Date Signature of Supervisor Wisconsin Medicaid Provider Number

To be completed by the Clinic Manager (required for mental health non-billers only):

NOTE: Outpatient mental health/AODA clinics who employ non-billing providers *must* be certified by the Division of Community Services *and* Wisconsin Medicaid. Staff of non-51.42 board clinics providing Wisconsin Medicaid services *must* be individually certified.

On behalf of (Clinic Name) _____, (Wisconsin Medicaid Provider Number) _____, I hereby acknowledge and agree to the above payment arrangement. I understand that Wisconsin Medicaid checks for services provided by the above non-billing provider will be payable to the clinic and reported under this IRS#.

_____ _____ _____
Date Name and Signature of Clinic Manager Employer IRS #

Clinic Address:_____ Phone:(_____)_____